Sex Offender Law Report

Vol 6 No. 3 ISSN 1529-0697 Pages 33 - 48 April/May 2005

Psychological Treatment of Sex Offenders: Current Status

by Philip H. Witt, Ph.D., and Kristen M. Zgoba, Ph.D.

Editor's Note: This article is the second in a series assessing the current state of sex offender assessment and treatment. The first article, which was published in 6 (2) SLR, focused on risk assessment of sex offenders in many jurisdictions. (Philip H. Witt and Lori H. Lessin, "Overview of Sex Offender Risk Assessments," 6 (2) SLR 19 (Feb/Mar 2005).) This article examines the development of risk assessment guidelines and explains how such actuarial assessments help improve the ability to predict risk at various stages of the legal and treatment process. This article focuses on how to assess dynamic risk factors – a key focus of current therapeutic practices. In particular, the article helps to explain how it is possible to assess change, how positive changes in dynamic risk factors can be balanced against poor static, historical risk factors, and what structures are available to assess change. The next article in the series will discuss the effectiveness of sex offender specific treatment.

Because of the public revulsion that sex crimes cause, there have been legal and clinical efforts for decades to reduce recidivism. The legal measures have included a variety of "sexual psychopath" laws, that is, laws that select sex offenders or some subgroup of sex offenders (typically those considered at highest likelihood of reoffending) for special sentencing provisions. These special sentencing provisions frequently include mandatory psychological treatment, based on the assumption that such

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Possession of Child Pornography: Food for Fantasy, Fuel for Molestation, or Deviant Curiosity?

by Jennifer McCarthy

In response to a 2002 inquiry as to whether there is a connection between sex offenders who trade or possess child pornography and sex offenders who molest children, seasoned FBI agent Michael J. Heimback answered, "resounding and alarming—yes," in his testimony before the Subcommittee on Crime, Terrorism, and Homeland Security, the Committee on the Judiciary, and the United States House of Representatives.

While Agent Heimback reported having no awareness that child pornography alone stimulates a sexual attraction to children in individuals who do not already have a sexual proclivity toward children, he reported that according to the FBI's experience in investigating such crimes and his personal consultation with "experts" who study this phenomenon, there is a "strong correlation between child pornography offenders and molesters of children."

In support of this statement, Agent Heimback refers to information gathered from three sources: the FBI arrests of 90 individuals associated with an electronic group called "Operation Candyman"; statistics on child pornographers investigated by the U.S. Postal Service; and a study conducted by Dr. Andres E. Hernandez on incarcerated sex offenders who participated in a sex offender treatment program at a Federal Correctional Institute in Butner, NC. According to Agent Heimback, 13 of the 90 individuals arrested during Operation Candyman "who chose to make inculpatory statements" reported molesting 48 children combined. Regarding U.S. Postal statistics, Agent Heimback reported that the numbers indicate consistently that 40% of the child pornographers investigated were determined to be child molesters. (J. Heimbach, "Internet Child Pornography," Congressional testimony before the Subcommittee on Crime, Terrorism, and Homeland Security, Committee on the Judiciary, U.S. House of Representatives (2002).)

Data from Dr. Hernandez' study indicates, according to Agent Heimback, that the "majority" of individuals who participated in the study and who were convicted of child pornography offenses, were responsible for having sexual contact with a significant amount of children that went undetected by law enforcement.

While the above sources of information definitely contribute to our knowledge of sex offenses involving child pornography, they in no way support the "resounding" conclusion made by Agent Heimback. In fact, they reflect the ongoing limitations of research conducted to date on the phenomenon of how viewing child pornography contributes to child molestation.

Moreover, Agent Heimback's conclusion reflects the misinterpretation of research results that is shared by not only other criminal justice agencies, but also by researchers who conduct studies on the phenomenon and practitioners who treat sex offenders who have been convicted of possessing child pornography. Some would argue that it is

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treatment will reduce recidivism. Because sexual offenders are often believed to possess a unique pathology that can be rehabilitated or managed by treatment, sexual offender treatment programs are prevalent inside and outside of prisons. Moreover, the specialized sexual offender treatment provided to sexual offenders is based on the assumption that sexual offenders specialize in sexual crimes and are unlike other criminal offenders, who may commit a wide range of crimes.

The public, however, has a very different view of sex offenders. Hardly a day passes without hearing or reading a variant of the following in the news media: "All sex offenders repeat their crimes. They are hopeless. Treatment cannot help them." Those of us who specialize in evaluating or treating sex offenders regularly hear such comments from educated friends, as well as from nonspecialist colleagues.

Such skepticism is common among legislators as well. For example, in New Jersey, after serving his maximum sentence, Jesse Timmendiquas was released from New Jersey's specialized sex offender treatment, the Adult Diagnostic and Treatment Center (ADTC). In 1994, a few years after his release, Timmendiquas raped and murdered Megan Kanka. The public outrage following this brutal and tragic event led to, among other things, a legislative task force that expressed serious doubts about the efficacy of the ADTC's program specifically, and sex offender treatment generally.

Methodological Issues

Treatment outcome research with sex offenders presents significant difficulties. First, there is the question of what outcome measure to use. The most common is recidivism, that is, what percentage of a given group of sex offenders reoffend. However, studying recidivism is not as simple as it may seem at first glance. Methodological differences can explain some of the wide variation in recidivism rates among sexual offender studies. As discussed in Zgoba et al., these disparities include:

1. Lack of a standard definition of recidivism: Recidivism is variously defined as a new sex offense arrest, a new sex offense conviction, a new arrest of any kind, a new conviction of any kind, or even a new technical violation of parole.
2. Underreporting of sex offenses: Because sex offenses are underreported, probably more than other offenses, it is difficult to ascertain true reoffense rates.
3. Lack of a homogeneous sample: Recidivism studies frequently aggregate diverse groups of offenders, failing to separate offenders into meaningful subgroups. Different subgroups of offenders reoffend at different rates.
4. Variation in follow-up period: The longer the follow-up period, the more opportunity offenders have to reoffend and the higher the rate of recidivism is likely to be.
5. Attrition: Some participants drop out of the studies during treatment. Some are unable to be located during the lengthy follow-up period. (K. Zgoba, W. Sager, and P.H. Witt, "Evaluation of New Jersey's Sexual Offender Treatment Program at the Adult Diagnostic and Treatment Center: Preliminary Results," 31 J. of Psychiatry and Law 136-37 (2003).)

Treatment Integrity Issues. In addition, there are treatment integrity issues. At times, it is difficult to know exactly how a treatment model was implemented. Together these disparities have provided conflicting messages about sex offender recidivism to both the academic community and the public; accordingly, the introduction of these systematic inconsistencies has skewed results as well as public perception.

There are a number of levels of methodological rigor in treatment outcome studies, namely:

1. Blind randomized trials;
2. Non-blind randomized trials;
3. Non-randomized trials with a comparison group;
4. Non-randomized trials without a comparison group; and
5. Qualitative studies.

Incarcerated Persons Are a Vulnerable Population. For medical research, such as trials of new drugs, randomized trials (blind if possible) are required. Blind randomized trials eliminate potential sources of experimenter or procedural influence on the results. However, such studies are rare in social science outcome research, particularly when evaluating treatment programs in the correctional settings. Authorities have questioned whether correctional subjects

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Sex Offender Law Report™

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Sex Offender Law Report (ISSN 1529-0697) is published bimonthly by Civic Research Institute, Inc., 4478 U.S. Route 27, P. O. Box 585, Kingston, NJ 08528. Periodicals postage paid at Kingston, NJ and at additional mailing office. (USPS# 016-7947) Subscriptions: $159 per year plus postage and handling in the United States and Canada. $30 additional per year elsewhere. Vol. 6, No. 3, April/May 2005. POSTMASTER: Send address changes to Civic Research Institute, Inc., P.O. Box 585, Kingston, NJ 08528. *Sex Offender Law Report* is a registered trademark owned by Civic Research Institute, Inc., and may not be used without express permission.

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have the ability to give voluntary and informed consent, given their incarcerated status. For this reason, incarcerated persons are considered a vulnerable population, and stringent precautions against exploitation are required. Moreover, if there is a general belief—even if not empirically supported—that a treatment program or method is beneficial to an offender group, then there are ethical concerns about depriving a control group—random or otherwise—of access to that treatment.

For the above reasons, many studies of sex offender treatment have used non-random comparison groups, usually with an attempt to match the comparison group to the treatment group on important variables, such as demographic characteristics and offense. Unfortunately, matched comparison groups are difficult to obtain in evaluating sex offender treatment. Many treatment groups receive treatment because they are unique in some important way—having a specified diagnosable mental disorder, highest number of prior sex offenses, or being the highest risk, for example. Consequently, finding an appropriate comparison group presents challenges. Moreover, if the comparison group has the lowest base rate of offending, as is frequently the case when the treatment group was selected based on high risk or high offending base rate, then the results of the study may be attenuated because there is little likelihood that a treatment effect will be significant in the comparison group.

All these methodological difficulties cloud the results of outcome studies with sex offenders, making the range of results difficult to interpret. Nonetheless, in the past few decades, the field has advanced.

Sex Offender Treatment

The treatment model of choice in recent years, at least in North America, is a cognitive-behavioral/relapse prevention one. (R.E. Freeman-Longo, S. Bird, W.F. Stevenson, and J.A. Fiske, *1994 Nationwide Survey of Treatment Programs and Models Serving Abuse-Reactive Children and Adolescent and Adult Sex Offenders* (1994); see also P.H. Witt, E. Rambus, and T. Bosley, "Current Developments in Psychotherapy for Child Molesters," 11 Sexual and Marital Therapy 173 (1996).) Recent research, which we shall review below, has focused almost entirely on such programs. Cognitive-behavioral treatment aims to change both an offender's maladaptive thinking and actions. Although such a statement might be made about a range of treatment approaches, cognitive-behavioral treatment frequently has a distinctly educational tone, with structured teaching modules and out-of-session tasks (homework assignments). Moreover, relapse prevention, an approach originally developed on substance abusers, aims to help offenders recognize and effectively manage their precursors to sex offending.

Cognitive-Behavioral Program Components. In institutional programs, a typical cognitive-behavioral program might include the following components:

1. **Sex offender characteristics:** This module is sometimes referred to as an introduction to treatment, including identification of types and motivations of sex offenders. The module allows patients to understand what treatment will involve and on what issues they will be working.
2. **Victim empathy/awareness:** The victim empathy module assists the offender in identifying the short- and long-term consequences of the sexual abuse on victims in general, and if possible, on the offender's victim in particular.
3. **Cognitive restructuring:** This module examines the justifications that the offenders use to convince themselves that their sexually offensive behavior is not so reprehensible. The goal is to assist the offender in accepting more responsibility for his behavior.
4. **Deviant sexual acting-out:** The offender is helped to identify his unique sexual assault cycle of motives, emotions, thoughts, and behaviors. Relapse prevention strategies for managing personal risk factors are sometimes addressed in this module or in a separate module.
5. **Anger management:** Because some offenders have difficulties appropriately modulating and expressing anger, this module works on identifying the precipitants of anger, preventing anger from overwhelming the offender, and appropriately expressing anger.
6. **Assertiveness training:** This module identifies assertive, passive, and aggressive behavior styles and assists the offender to adopt a more assertive style.
7. **Social skills training:** Social skills training involves the concrete conversational skills needed to initiate and maintain friendships, business, and romantic relationships.
8. **Autobiographical awareness:** Assigned autobiographies provide a means for the offender to explore his life and examine the determinates and decisions that shaped his life.
9. **Sex education:** Because many sex offenders are poorly informed regarding human sexuality, sex education focuses not only on basic biology, but also sexual myths and cultural expectations about sexual performance.
10. **Stress reduction:** Relaxation training or meditation is a common component of sex offender treatment, based on the assumption that difficulty managing anxiety and stress is a common problem with this population, and that overwhelming stress can lead to inappropriate behavior.
11. **Chemical abuse:** Because a substance abuse disorder is commonly comorbid with the sex offending behavior, a component of treatment focusing on effectively managing substance use is commonly performed with sex offenders. (See R. Green, "Psycho-Educational Modules," in B.K. Schwartz and H.R. Cellini, eds., *The Sex Offender: Corrections, Treatment, and Legal Practice* Ch. 13 (1995).)

Flexibility in Programs Necessary. Depending on the offender's particular set of problems, the above modules can be tailored to his needs. Given the heterogeneity of sex offenders, treatment programs must be flexible to allow different treatment emphases with different offenders. (Cornwell, Jacobi, and Witt, "The New Jersey Sexually Violent Predator Act: Analysis and Recommendations for the Treatment of Sex Offenders in New Jersey," 24 (1) Seton Hall Legislative J. 17 (1999).) In institutional treatment programs, whether in prisons or psychiatric facilities, the above treatment components are typically implemented in a broader context of phases or levels. (See W.L. Marshall, Y.M. Fernandez, and T. Ward, *Sourcebook of Treatment Programs for Sexual Offenders* (1998).)

Sex Offender Treatment Evaluation Studies

Beginning in the late 1980s, investigators put forth increased effort to evaluate the efficacy of sexual offender treatment regimens and to determine sexual offenders' levels of recidivism. Media attention sur-

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rounding the reporting of numerous child molestation and homicide cases and the recognition of the extent of sexual offending and victimization led to the realization that a paucity of sexual offense research existed. These two factors resulted in the movement to collect and disseminate information on sexual offenders. We shall review and summarize a few recent representative studies.

Treatment Can Reduce Recidivism. A study conducted by Nicholaichuk, Gordon, Gu, and Wong at the Correctional Service of Canada offers a methodologically sound design and proposes that treatment, specifically cognitive-behavioral treatment, can reduce the recidivism of sexual offenders. Using a comparison group matched on age at index offense, date of index offense, and prior criminal history, the authors compared roughly 300 each treated and untreated offenders for an average follow-up period of six years. Almost 15% of treated sex offenders were convicted of a new sexual offense, while 33.2% of untreated, matched sex offenders were reconvicted of new sex offenses, a 50% reduction in recidivism due to treatment. (Nicholaichuk, Gordon, Gu, and Wong, "Outcome of an Institutionalized Sexual Offender Treatment Program: A Comparison Between Treated and Matched Untreated Offenders," 12 (2) Sexual Abuse: A J. of Research and Treatment 139-53 (2000).)

Ohio Prison System. In 2001, the Ohio Department of Rehabilitation and Correction examined a large 10-year follow-up period of sex offenders released from the Ohio prison system in the year 1989. Offenders involved in treatment programs had lower levels of recidivism than those not involved in treatment, 33.9% and 55.3% respectively. Although the treatment offered was not extensive and was admittedly more instructional than therapeutic, offenders who participated had decreased rates of recidivism. ("Ten-Year Recidivism Follow-up of 1989 Sexual Offender Releases" (Apr. 2001), retrieved from the Ohio Department of Rehabilitation and Correction at *www.drc.state.oh.us.*)

Multivariate Analysis. An analysis by Scalora and Garbin provided a retrospective examination of sex offenders treated at a secure facility utilizing a cognitive-behavioral program matched with an untreated correctional sample. Variables studied included demographic, criminal history, offense related, and treatment progress. Recidivism was assessed through arrest data. Multivariate analyses suggested that recidivism was significantly related to quality of treatment involvement, offender demographics, offense characteristics, and criminal history. Successfully treated offenders were significantly less likely to subsequently reoffend. (Scalora and Garbin, "A Multivariate Analysis of Sex Offender Recidivism," 47 (3) Int'l J. of Offender Therapy & Comp. Crim. 309-23 (2003).)

Vermont Study. A current study by McGrath, Cumming, Livingston, and Hoke examined the recidivism rates of 195 adult male sex offenders who were referred to a prison-based cognitive-behavioral treatment program in Vermont. Of this sample, 56 participants completed treatment, 49 entered but did not complete treatment, and 90 refused treatment services. Although participants were not randomly assigned to treatment conditions, there were no between-group differences on participants' pretreatment risk for sexual recidivism. Over a mean follow-up period of approximately six years, the sexual reoffense rate for the completed-treatment group was 5.4% versus 30.6% for those with some treatment and 30.0% for the no-treatment groups. Lower sexual recidivism rates were also found among those participants who received aftercare treatment and correctional supervision services in the community. (McGrath, Cumming, Livingston, and Hoke, "Outcome of a Treatment Program for Adult Sex Offenders: From Prison to Community," 18 (1) J. of Interpersonal Violence 3-17 (2003).)

Intensive Treatment Can Bring Down Recidivism Level of High Risk Population. These findings are comparable to a project undertaken by the New Jersey Department of Corrections at the Adult Diagnostic Treatment Center (ADTC) which analyzed 10-year recidivism of repetitive and compulsive sex offenders (that is, those with a relatively high base rate of sexual offending) who were released from the ADTC in the years 1990 and 1991. Sex offenders who were not found to be repetitive and compulsive and were released from the general prison population for the year 1990 provided a comparison group. Treated sex offenders from the ADTC had a 10-year sexual recidivism rate of 9%, while the sex offenders released from the general prison population had a sexual recidivism rate of 13%; however, the differences did not meet the 0.05 level of significance. The levels of nonsexual recidivism for both the ADTC sample and the general population sex offenders were considerably higher, 26% and 44% respectively, with the ADTC rate being significantly lower. Furthermore, 65% of the sample of sex offenders from the ADTC did not show any recidivism, whereas only 43% of the general population had no recidivism. In summary, the authors found that intensive treatment can bring down the recidivism level of a high risk population (that is, those offenders found to be repetitive and compulsive, so sentenced to the ADTC) to at least the level (if not slightly below) that of a nonrepetitive and noncompulsive population. (Zgoba et al., supra.)

Meta-Analyses Suggest Different Predictors for Recidivism. Beyond individual outcome studies, Karl Hanson and his associates have conducted a number of meta-analyses (i.e., examining pooled data from multiple studies). Although their design does not allow direct evaluations of treatment efficacy, a number of their meta-analyses have offered encouraging results on sexual offender treatment. A meta-analysis conducted by Hanson and Bussiere contained 61 studies with an overall sample size of 23,393 sexual offenders. On average, the sexual offense recidivism rate was found to be low at 13.4% of the sample recommitting a sexual offense, while 36.3% of the sample committed a general re-offense. Particular subgroups of sexual offenders, as well as offenders who prematurely terminated treatment, recidivated at higher levels. The results of this analysis suggest that there are different predictors for nonsexual and sexual recidivism among offenders. (Hanson and Bussiere, "Predicting Relapse: A Meta-Analysis of Sexual Offender Recidivism Studies," 66 (2) J. of Consulting & Clinical Psych. 348-62 (1998).)

A subsequent and more recent meta-analysis conducted by Hanson, Gordon, and Harris examined the effectiveness of psychological treatment for sexual offenders by summarizing 43 studies, resulting in a sample size of 9,454. Similar to the previous studies, the sexual re-offense rate was lower for the treatment group (12.3%) versus the comparison group (16.8%). The nonsexual re-offense rates for the treatment and nontreatment groups were 27.9% and 39.2% respectively. Although older treatment modalities yielded little efficacy, the current psychological treatments, namely cognitive-behavioral treatment, were associated with reductions in both general and sexual recidivism. (Hanson, Gordon, and Harris, "First Report on a Collaborative Outcome Data Project on the Effectiveness of Psy-

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chological Treatment for Sexual Offenders," 14 (2) Sexual Abuse: A J. of Research and Treatment 169-94 (Apr. 2002).)

Treatment Efficacy Remains a Controversial Area

As some have noted:

> Sex offender efficacy studies have reflected, at various times, unfaltering support for the rehabilitation of sex offenders juxtaposed with the belief that nothing works and that therefore sex offenders should be punished as severely as possible through lengthy incarceration. Few efficacy study results have consistently supported sex offender treatment, rendering the topic controversial. (Zgoba et al., supra, 138.)

Treatment efficacy for sex offenders remains a controversial area. Applied research is always limited by constraints of data collection, retrieval systems, and by policies that were not designed with research in mind. Numerous methodological discrepancies and systematic inconsistencies have led to conflicting findings within sex offender research. Definitive findings have remained elusive.

Nonetheless, our review above suggests reason for cautious optimism. Although it is true that the various methodological difficulties discussed above to some extent limit one's ability to make generalizations about treatment efficacy, on balance, the literature supports the notion that treatment of sex offenders works, albeit imperfectly. The studies and meta-analyses reviewed above indicate generally lower recidivism rates for treated sex offenders (particularly those who complete treatment), particularly if offenders are treated with the most current cognitive-behavioral methods. As one authority recently put it:

> In summary, at this time there is no definitive answer to the question of whether treatment effectiveness has been determined. However, the picture is not as grim as is sometimes assumed, and recent advances in treatment approaches seem to be showing promise in having at least a small impact on recidivism. (W.D. Murphy, "Management and Treatment of the Adult Sexual Offender," in B.J. Cling, ed., *Sexualized Violence Against Women and Children* 232 (2004).)

At present, methodological problems hamper sex offender treatment outcome research. Although the data suggest that sex offender treatment is effective, it is difficult to state exactly the size of the treatment effect or to generalize to a wide range of populations. Future endeavors should be directed at closing the existing gaps and eliminating discrepancies, mainly by way of standardizing information between agencies and among states. Although this task seems insurmountable now, small steps need to be taken toward collaborative data collection. Unfortunately, empirical outcome research is frequently a low priority in state and federal budgets for correctional populations. Without evaluation, treatment programs have no method by which they can continuously assess the effectiveness of their program.

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Available from: Journal of Law and Policy, Brooklyn Law School, 250 Joralemon Street, Brooklyn, NY 11201.

Sentencing of Adult Offenders in Cases Involving Sexual Abuse of Children: Too Little, Too Late? A View From the Pennsylvania Bench

by Debra Todd

The proper sentence for an adult convicted of the sexual abuse of a child is problematic. It can be difficult to find an appropriate sentence for the severity of the crime and still keep the punishment in proportion to other offenses. This article discusses current Pennsylvania law in regard to sentencing of those convicted of these crimes. Some of the material, especially the historical background and the rational for the severity of sex offender sentences will doubtless be familiar. However, the author has served as a superior court judge in Pennsylvania for several years and this gives her article an uncommon perspective and authority.

Historical and Current Attitudes in Treatment of Children

The author begins by discussing how the concept of legal protection for children has evolved. Children were historically treated as property of their parents and thus subject almost entirely to their parents and guardians' control with little special protection by the government. This began to change in the 19th century as children began to be recognized as individuals deserving of protection in their own right. The sense that the government needs to provide special protection to children has only increased since, accelerating significantly in the post-World War II era as the problem of child abuse has become a national issue. The author provides a detailed breakdown of abuser types, abused children's ages, and what type of abuse is currently being reported to the criminal justice system. It is noted that families, not outsiders, form the main body of abusers.

The author provides several anecdotes showing that, despite decades of publicizing the problem of sexual abuse of children, people in the legal system, media, and the general public still do not always treat the sexual abuse of children with the seriousness it deserves. She found an instance of a trial judge stating that "he could not believe that the legislature intended to brand for life with the scarlet letter of a felony sex conviction a teenager who engaged in consensual sex with another sexually experienced teenager under the facts of this case," when the individual was a 19-year-old charged with having sex with a 13-year-old. Another case is mentioned where a judge refused to hold a case over for trial because "I'm not going to ruin the life of this 50-year-old man on the testimony of a five-year-old."

Perpetrators and Crimes

The author then deviates from the discussion of abuse to discuss the goals of the

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